TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VISTA MEDICAL CENTER HOSPITAL

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number
M4-03-8980-02

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 28, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the Carrier also referenced an unidentified portion of the charges for lack of pre-authorization for medical supplies, other hospital services, laboratory, x-rays, and pharmacy charges. The application of this payment exception code is in violation of the Texas Administrative Code, as the services are not required to be pre-authorized under 134.600 with an in-patient stay. Finally, it appears that the carrier has not made payment for any of the implant supplies as according to the Explanation of Benefits. No payment was made for Revenue Code 278 that was charged in the amount of $45,440.00. Therefore, the carrier's reimbursement for the dates in dispute was not made pursuant to the TWCC Fee Guideline regarding in-patient care."

Requestor's Supplemental Position Summary Dated December 15, 2014: "Please allow this letter to serve as a supplemental statement to Vista Medical Center Hospital's (VMCH) originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment… The medical records on file with MDR show this admission to be a complex lumbar fusion at multiple levels. This complex spine surgery which is unusually extensive for at least the following reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for at last the following reasons."

Amount in Dispute: $29,770.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I have been retained by Employers Insurance Company to represent them in connection with the enclosed medical payment dispute."

Response Submitted by: Hanna & Plaut, L.L.P.

Respondent's Supplemental Position Summary: "Total payment made per TX FS: $53,231.45."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
August 28, 2002 through September 2, 2002	Inpatient Hospital Services	$29,770.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.600, 26 *Texas Register* 9872, effective January 1, 2002, requires preauthorization for inpatient hospital services.
4. 28 Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z585-The charge for this procedure exceeds fair and reasonable.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - X170-Pre-authorization was required, but not requested for this service per TWCC rule 134.600.
   - X143-This charge is a duplicate of another charge.
   - X212-This procedure is included in another procedure performed on this date.
   - X013-Payment is not recommended for personal items during hospital stay.

7. Dispute M4-03-8980 History
   - Dispute was originally decided on April 6, 2005.
   - The original dispute decision was appealed to the State Office of Administrative Hearings (SAOH).
   - SOAH issued a decision.
   - The SOAH decision was appealed to District Court under case number D-1-GN-08-000990.
   - The 345th Judicial District remanded the dispute to the Division pursuant to an agreed order of remand dated January 30, 2012.
   - As a result of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
   - M4-03-8980-02 is hereby reviewed.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Does a preauthorization issue exist?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008

opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this dispute supplemented the original MDR submissions. The division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate. Documentation filed by the requestor and respondent to date is considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold…" In that same opinion, the Third Court of Appeals states that the stop loss exception "…was meant to apply on a case-by-case basis in relatively few cases." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, 28 Texas Administrative Code §134.401(c)(6)(A)(v) states that "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the respondent finds that the carrier deducted $9.00 in charges for personal items in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $110,659.95. The Division concludes that the total audited charges exceed $40,000.00.
2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services" and further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." In its position, the requestor states:

   > The medical records on file with MDR show this admission to be a complex lumbar fusion at multiple levels. This complex spine surgery is unusually extensive for at least the following reasons: This type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; This type of surgery has the risks of bleeding, nerve root damage, blood clots in the region causing pulmonary embolism, a spinal headache requiring additional treatment in the hospital and the possibility that a drain will be needed to prevent blood from building up at the site and, This type of surgery required a physician for neuromonitoring, a cell saver, additional trained nursing staff and specialized equipment thereby making the hospital services unusually extensive and; Medicare length of stay for this DRG is 3.7 days and the median length of stay for workers' compensation inpatient admission is three days, whereas the length of stay for this admission of 5 days exceeds both Medicare LOS and the median LOS for workers' compensation.

   The requestor discusses some case-specific medical factors in support of its contention that the disputed services are unusually extensive; however, the requestor fails to discuss or demonstrate how these factors may be considered unusually extensive when compared to similar spinal surgeries, services, or admissions. Furthermore, the requestor has not provided information or documentation to support the basis for its conclusion of a median length of stay for workers' compensation inpatient admissions as being three days. The Requestor does not specify whether any such data concerned Texas hospitals and addressed services in the year 2003 when the services in this matter were provided. No additional information was found to

substantiate why this surgical operation involved unusually extensive services compared with similar operations; therefore, the division finds that the requestor did not meet the requirements of 28 Tex. Admin. Code § 134.401 (c)(6)(A)(ii).

3. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > The medical and billing records on file with MDR also show that this admission was unusually costly for at least the following reasons: The median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; As mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment such as large bore IV's and an arterial line and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries and; It was necessary to purchase expensive implants for use in the surgery.

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for similar spinal surgery services or admissions. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar spinal surgery services or admissions.

4. 28 Texas Administrative Code §134.600(h)(1) requires preauthorization for "inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay."

   A review of the submitted explanation of benefits finds that the respondent denied reimbursement of $715.00 for revenue code Y9990-Other Hospital Services, $12.08 for Y3000-Lab, $70.00 for Y3200-XRay DX and $41.40 for Y2500-Pharmacy.

   The requestor states in the position summary that "the Carrier also referenced an unidentified portion of the charges for lack of pre-authorization for medical supplies, other hospital services, laboratory, x-rays, and pharmacy charges. The application of this payment exception code is in violation of the Texas Administrative Code, as the services are not required to be pre-authorized under 134.600 with an in-patient stay."

   The respondent stated "Paid at the Texas stop loss reimbursement factor 75% of billable charges to total $53,231.45. Claimant was admitted one day before surgery on 8/28/02. Denied all charges for 8/28/02 as not authorized except pre-op labs and chest x-ray."

   The Division reviewed the submitted documentation and finds that the respondent did not support the denial of the above specified services based upon a lack of preauthorization in accordance with 28 Texas Administrative Code §134.600(h)(1. As a result, a preauthorization issue does not exist in this dispute.

5. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" Review of the submitted documentation finds that the length of stay for this admission was 5 surgical days; therefore the standard per diem amounts of $1,118.00 multiplied by the 5days result in a total allowable amount of $5,590.00.
   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
   - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $45,440.00.
   - Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement can be recommended.

   - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $265.35/unit for Thrombin 10,000 unit, and $289.00/unit for Dilaudid PCA 100ml. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

   The division concludes that the total allowable for this admission is $5,590.00. The respondent issued payment in the amount of $53,231.45. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/16/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.